Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMPREHENSIVE HEALTHCARE ASSOCIATES
3131-F EAST 29TH STREET
BRYAN TX 77802

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

BRYAN ISD

Carrier's Austin Representative Box

Box Number 43

MFDR Tracking Number

M4-04-6733-01

MFDR Received Date

February 18, 2004

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Not fair and reasonable reimbursement"

Amount in Dispute: $6,963.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This firm has been retained to represent the Bryan ISD with regard to its self-insured workers' compensation program and the above-referenced Request for Medical Dispute Resoltuion which has been filed by or on behalf of Comprehensive Health Care Accociates. Please direct all future communications to the attend of the undersigned attorney for Bryan ISD."

Response Submitted by: Naman Howell Smith & Lee, PO Box 1470, Waco, TX 76703

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2003, February 19, 2003, February 20, 2003, February 24, 2003 February 25, 2003, February 27, 2003, March 4, 2003, March 5, 2003, March 6, 2003	CPT Code 97799-CP	$6,963.00	$ 3,913.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.1 sets out the procedures for fair and reasonable reimbursement.
3. 28 Texas Administrative Code §134.202 sets out the procedures for reimbursement
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 16, 2003, June 27, 2003, May 6, 2003
   - M – No MAR

Issues

1. Did the requestor support their request for additional fair and reasonable reimbursement?
2. Is the requestor entitled to reimbursement?

Findings

1. In support of the requested reimbursement, the requestor submitted a previous Medical Dispute Resoltuion Findings and Decision and redacted explanations of benefits, and selected portions of EOBs, from various sample insurance carriers. The requestor did not discuss or explain how the sample EOBs support the requestor's position that additional payment is due. The carriers' reimbursement methodologies are not described on the EOBs. Nor did the requestor explain or discuss the sample carriers' methodologies or how the payment amount was determined for each sample EOB. The requestor did not discuss whether such payment was typical for such services or for the services in dispute.

   1996 Medical Fee Guideline, Medicine Groud Rule (II)(C) indicates if the Requestor is a CARF accredited program modifier AP would be applied. If the Requestor were not a CARF accredited program than 20% reduction would be applied. The Requestor did not use the modifier AP so billing is subject to this 20% reduction.

   Per 28 Texas Administrative Code §134.202(e)(5)(E)(ii) reimbursement shall be $125.00, *adopted to be effective May 16, 2002, 27 Tex Reg 4048*.

2. Review of the submitted documentation finds that reimbursement is due. Therefore, the billed amount of $125.00 per hour will be reduced 20% that equals $100.00 per hour x 61 billed hours = $6,100.00 - $2,187.00 (Carrier reimbursement) = $3,913.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,913.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,913.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 2, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.